APPLICATION FOR THE MADAP TRANSITIONAL ASSISTANCE PROGRAM (TAP)

Instructions:

- Select the reason you are applying for transitional assistance.
- **TAP eligibility requirements are:** HIV+ status, eligibility for Maryland Medicaid (MA) or Low-Income Subsidy (also called "Extra Help" or LIS) and MADAP formulary medications being currently prescribed.
- A copy of the electronic confirmation may be used if the client applied for Medicaid or Low-Income Subsidy on line. If you are applying for Medicaid and you do not have the online confirmation you must complete a copy of a Medicaid application signed by the client. If you have applied for Low-Income Subsidy by telephone, please write the confirmation number in the space provided below.
- **Before** applying for TAP, a **complete** application **must** be submitted to the applicable program either for Medical Assistance or Low-Income Subsidy.
- Applications for TAP must be completed and submitted **by an HIV Case Manager**.
- Applications for TAP should be faxed to: **410-333-2608, 410-244-8696 or 410-244-8617**. For phone inquiries call MADAP at **410-767-6535**.

Applying for (check box):	**Low Income Subsidy** ☐	**Maryland Medicaid** ☐

Required Information (all questions must be answered)

Client: First Name	M. I.	Last Name	**Social Security Number:**

Date of Birth: / /	**Sex:** ☐ Male ☐ Female ☐ Other **Transgender:** ☐ Male to Female ☐ Female to Male

United Sates Citizenship Status:

Is the client a US citizen? ☐ Yes ☐ No

Is the client an Asylee? ☐ Yes ☐ No

Is the client a lawful permanent resident of the U.S.? ☐ Yes ☐ No Card Issue date: ___ /___ / ___

The client is not a citizen or lawful permanent resident. ☐ Yes ☐ No

Marital Status: □ Never Married □ Married □ Separated □ Divorced □ Widowed

Spouse: First Name	M. I.	Last Name	**Social Security Number:**

Number of children natural or legally adopted in the home under 18 years of age:_____

Race(check up to five):

- ☐White
- ☐Black or African American
- ☐American Indian/Alaskan Native
- ☐Native Hawaiian
- ☐Asian

Race of Origin (may select up to all):

- Native Hawaiian: ☐Guamanian or Chamorro; ☐Samoan; ☐Other Pacific Islander
- Asian: ☐Asian Indian; ☐Korean; ☐Chinese; ☐Vietnamese; ☐Japanese; ☐Filipino; ☐Other Asian

Ethnicity(check one):

- ☐Hispanic/Latino
- ☐Non-Hispanic

Ethnicity Origin(may select up to all)

- Hispanic/Latino: ☐Mexican, Mexican American, or Chicano/a; ☐Puerto Rican; ☐Cuban; ☐Another Hispanic, Latino/a, or Spanish origin

Preferred Language for:

Reading:

☐ **English** ☐ **Spanish** ☐ **Other: _____**

Speaking:

☐ **English** ☐ **Spanish** ☐ **Other: _____**

Home Address:	**Apt No.**	**City, State, Zip code:**	**Homeless:** ☐ **Yes** ☐ **No**
Mailing Address: (if different from home address)	**Apt No.**	**City, State, Zip code:**	

Phone Numbers:	Home:	Messages: Yes: ☐ No: ☐	Cell:	Messages: Yes: ☐ No: ☐
Client is HIV Positive:	☐ Yes	☐ No (if no, client is ineligible. Stop here)		

List of MADAP formulary medications being currently prescribed to client:

1.	2.	3.
4.	5.	6.

Prescribing Clinician's Name:	First Name:	Last Name:	Phone Number:

Lab Results, (not more than 12 months old):

☐ Results of Last CD4 Test:		Date of Test:	/ /
☐ Results of Last Viral Load:		Date of Test:	/ /
☐ Results are **pending** and not available at this time (date of most recent test):			/ /

Does client have an *urgent* need for medication due to CD4 count below 200 and/or current opportunistic infection and/or less than 2 week's supply of medication (listed above)?	☐ Yes ☐ No

HIV Exposure Category (check one):

☐ MSM	☐ Hemophilia/coagulation disorder	☐ Transfusion Recipient
☐ IDU	☐ Heterosexual contact	☐ Mother HIV + (for child <12 years old)
☐ IDU & MSM	☐ Born in Pattern II Country	☐ Other (describe):

Income Type	Received	Self	How Often?	Spouse	How Often?	Child/ Children	How Often?
Wages	☐ Yes ☐ No	$		$		$	
Self-Employment	☐ Yes ☐ No	$		$		$	
Unemployment	☐ Yes ☐ No	$		$		$	
SSI	☐ Yes ☐ No	$		$		$	
SSDI	☐ Yes ☐ No	$		$		$	
Social Security	☐ Yes ☐ No	$		$		$	
Pension/Retirement	☐ Yes ☐ No	$		$		$	
Other Income:	☐ Yes ☐ No	$		$		$	

Do you have other insurance, including Medicaid that pays for health care? □ Yes □ No
If yes, please write the name of the insurance company or program and your ID/ policy number.

Declaration of HIV/AIDS Case Manager, Licensed Social Worker, or Registered Nurse assisting client with the Maryland Medicaid or Low-Income Subsidy and TAP applications:

☐	***Based on the information provided to me, the client appears to be eligible for Maryland Medicaid or Low-Income Subsidy.***
☐	***I have mailed the original MA application and all the supporting documentation required by MA. I am enclosing a copy of the completed application that was submitted to MA or to Maryland Health Connection.***
☐	***I have assisted the client with applying for Maryland Medicaid or Low Income Subsidy online.***
☐	***I have assisted the client with applying for Low Income Subsidy on the phone.***

Case Manager's Signature :	Date:	Case Manager's Printed Name:	Phone Number:

Organization:	Street Address:	City:	State:	Zip Code:

LIS Confirmation Number:	